

## ARTS & HUMANITIES

# From Empathy to Caring: Defining the Ideal Approach to a Healing Relationship

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In recent years, “empathy” has been identified as a form of emotional engagement beneficial to patient care. Although usage varies, the term refers to sharing the feelings of another as a means of coming to a direct appreciation of the other. Defined this way, however, empathy may lead to mistaken assumptions and an absence of corrective curiosity: Once we think we understand what another is experiencing, we perceive less need to ask, listen, and learn. We propose the process of “caring” in place of “empathy” to embody the ideal emotional and behavioral approach to patient care. Caring refers to both an emotional reaction to another and the expression of that reaction in action, independent of the sharing of the other’s emotion or experience. The expression of caring in the clinical context is close observation, precise listening, and responsive questioning, in concert with committed engagement and actions directly addressing the patient’s problem, stripped of any assumptions about what the other might or might not be experiencing.

## INTRODUCTION

“Empathy” is probably the most widely discussed of the spectrum of reactions physicians have to patients; a PubMed search using the keyword “empathy,” covering the years 1950 through 2005, listed 7,526 citations. Unlike “sympathy,” in common use since the 16th century, “empathy” was introduced into the English language just over 100 years ago; its earliest documented use was in 1904 [1]. The word

was created as a technical term by an English writer in discussing a concept of art appreciation elaborated 20 years earlier in a German paper; it is the literal English equivalent of the original German term for the concept “Einführung,” which translates to “feeling into.” It was first applied in the interpersonal realm in 1909 by E.B. Titchener [2]. Both in its original intent and in its current usage, the word is contrasted with sympathy: Empathy involves sharing the feelings of another as a means of com-

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ing to an appreciation of the other. In contrast, sympathy entails simply sharing the feelings of another [3,4]. It is postulated that through the physician's empathic sharing, the feelings of the patient, the patient's state — his feelings and thinking — is identified, enabling the physician to early appreciate and investigate issues of immediate concern to the patient.

### DEFINING “CLINICAL EMPATHY”

In dictionaries, empathy is described as an affective mental process. For instance, in Merriam-Webster's Unabridged Dictionary empathy is “... vicariously experiencing the feelings, thoughts, and experience of another ...” [5] Dr. Simon Auster describes an example of empathy:

“In 1959, I was interviewing a 19-year-old college freshman as a part of a study of college dropouts. Her family and other adults involved with her considered her to be a problem. She was described as impulsive and indifferent to her responsibilities and commitments, even those freely undertaken. Of particular concern was her presumed sexual activity, which she made only nominal efforts to conceal. As I listened, open to the words washing over me, I momentarily experienced her world. It was a world in which the present was eternal, and there was no future. In that instant, all of her behavior made perfect, logical, sense. I emphasize the brevity of the experience, because the associated dysphoria shocked me into self-awareness, re-establishing my personal boundaries.”

The encounter aptly captures the experience of sharing the feelings of another as a means of coming to an appreciation of the other. The architects of a leading psychometric instrument of physician empathy, however, explicitly redefine the term as “a cognitive (as opposed to affective) attribute that involves an understanding of the inner experiences and perspectives of the patient, combined with a capability to communicate this understanding to the patient.” [6] Their

definition corresponds to others' writing about physician empathy [7-9]. In her essay, “What is Clinical Empathy,” Halpern traces this transition from emotional to intellectual knowing to an emphasis on objectivity in 20th century medicine. She cites Sir William Osler's 1912 essay, “*Aequanimitas*,” in which he argues that “by neutralizing their emotions to the point that they feel nothing in response to suffering, physicians can ‘see into’ and hence ‘study’ the patient's ‘inner life.’” [10]

Halpern argues that empathy has both cognitive and affective elements. The cognitive component forms the basis and involves “imagining how it feels to be in another person's situation.” The affective component is what she terms “resonance” or “emotional attunement:” “While listening to an anxious friend, one becomes anxious, while talking with a coworker, one feels heavy, depressed feelings.” She characterizes resonance as “a kind of emotional back-drop” to the process of “trying to imagine what a patient is going through.” [10] It is a natural, emotional response to the plight of another. Elsewhere, Halpern describes an empathic encounter with a patient in which she “imagined what it would be like” to be in the patient's position and then describes the feelings that emerged from the cognitive process [11]. Recently, other scholars have adopted Halpern's model of empathy. For instance, Larson and Yao speak of “simple cognition” and “advanced cognition” as the precursors of the physician's affective reactions [12].

### THE TROUBLE WITH EMPATHY

While the experience of empathy in its standard non-medical definition may have value in patient care for the limited appreciation it affords of the patient's mental state, it is already not without risk. It is one thing to “feel into” an inanimate work of art — in the original meaning of empathy — where no direct information is available and error (if such a concept could apply) would have no more significance than perhaps a diminished appreciation of the work. It is an en-

tirely different matter to think one is experiencing or feeling what another is experiencing or feeling; that is an ungrounded assumption, and ungrounded assumptions can lead to error, compromising patient care. The “associated dysphoria” described above, for instance, reflects only the physician’s reaction to a brief sojourn into the patient’s world as experienced from the physician’s perspective, not the patient’s experience of his own world, which in the above case was not dystopian. A particularly unfortunate consequence of the assumption that empathy provides immediate knowledge of the patient’s state is that it provides a convenient justification for not asking questions — “If I know what my patient is feeling, I don’t need to ask” — especially the kinds of questions that may get an answer that the physician does not want to deal with.

This potential for error in equating the physician’s emotions with those of the patient is compounded further by the cognitive process of “imagining” proposed by scholars of clinical empathy, with or without the affective component [13-17]. First, it assumes the physician has correctly arrived at the source of the patient’s distress. In thinking about — or imagining — the patient’s circumstances, the physician must infer what aspects of the situation are most important to the patient and are driving the patient’s reaction; depending on the assumptions and personal issues the physician brings to the encounter, the inferences may or may not be correct. It further assumes that based on these initial thoughts, the physician will react in a way that leads to identification with the patient’s feelings; again, the physician’s reactions may or may not be congruent with those of the patient, now depending *both* on a) whether the physician has correctly assessed what is important to the patient, and b) whether the reaction is to the patient’s needs or to the physician’s needs as they might emerge in a similar situation.

Of greater concern, however, is the view of the authors of these and other papers on empathy that an observer’s experience,

of itself, can provide direct knowledge of another [9-13]. Such a perspective runs counter to extensive theoretical and empirical research on qualitative inquiry. The physician-patient encounter may be likened to a “participant-observer case study with an *n* of 1.” [18] Like the anthropologist or sociologist in the field, the physician is engaged in a process of data gathering that requires ongoing rigorous efforts to identify and set aside personal bias. The literature on qualitative inquiry extensively cautions against the hazards of imagining the predicament of the observed [19-20]. The emphasis is on “constant comparison,” which focuses on objective validation of what is observed, and on “reflexivity,” which involves explicitly recognizing and setting aside one’s own perspective [21-22].

In commenting on his brief, sole experience of empathy while interviewing a 19-year-old woman, quoted earlier, Auster noted:

“I have not had such an experience of another’s world since, nor do I think having one would advantage me in caring for another. Because in that instant I realized that I could arrive at the same appreciation of another’s situation through a systematic cognitive process that is ultimately more useful to him: By precisely observing his appearance and his context, his words (and this includes the particular words selected to express a thought, feeling, or action) and their actions, I construct from those observations a context in which it all makes logical sense and then ask whether my construct accurately reflects his experience. When it does not, I ask how it does not, and based on their reply, I make continuing adjustments to that construct until it is in line with the other’s reality. Such an approach, which is similar to the “grounded theory” of discovery [18], has several advantages over the kind of direct experience of the world of another such as I had with that young woman: First, it assures that I have an accurate picture of what is happening, both of the event and of the context; second, responding to my questions often puts

the patient in touch with his own perspective on his situation, a perspective that may be contributing to whatever difficulties he is experiencing; Third, my questions imply the possibility of alternative perspectives to the one he has — a kind of re-framing — that may point to opportunity and hope. Rewarded by the outcomes of this approach, and negatively conditioned by the dysphoria of that earlier experience, I haven't been empathic again."

## EMPATHY VS. CARING

Empathy, whether cognitive, affective, or both, does not necessarily involve caring. Just because I say, "I feel your pain," does not mean I am strongly motivated to do anything about it. Nor does it mean I will react in a way that is responsive to your needs, rather than to my own discomfort. Although framed as an antidote to detached concern, empathy is, in its own way, detached. Caring, in contrast, is a sustained emotional investment in an individual's well being, characterized by a desire to take actions that will benefit that person. Although the word is ancient [23], much of the literature on caring comes from the nursing field in the last 40 years [24-26], based on the work of Madeline Leininger, who defines caring as "those assistive, supportive, or facilitative acts toward or for another individual or group with evident or anticipated needs to ameliorate or improve a human condition or lifeway." [27] The focus has been on caring as a set of actions, behaviors, or as a "process of action." [28] This is consistent with the contemporary definition of caring as "the action of the verb, care," "to take thought for, provide for, look after, take care of." [23]

When we care for an individual, we may also empathize with them but doing so is not necessary and may be a distraction — or, as noted earlier, even misleading. The focus of empathy is the physician's emotions, rather than the optimal direct response to the patient's needs in the immediacy of the encounter. The significance of this distinction is often overlooked in discussions

of empathy and caring. In a recent collection of essays on caring, for instance, empathy consistently is regarded as a dimension of caring. As one author states: "Caring must address the emotions, and empathy is the characteristic term chosen to convey the need for those who do the caring to share, even if in an attenuated way, the emotion of the one being cared for." [29] Certainly, caring must address emotions, the physician's no less than the patient's, but we question whether it is prudent to introduce empathy, with its attendant risk of error, as a necessary component of quality patient care. The physician's emotions must be addressed insofar as they influence, at times profoundly, how the physician ultimately cares for the patient; of themselves, they are of no consequence, since the path from emotion to behavior is so contingent on qualities that vary infinitely across individuals and situations.

How is caring manifested? How might we respond when an individual comes to us with a problem and we wish simply to do what we can to help them? We propose that caring in the clinical setting expresses itself first as an intense effort to appreciate a patient's situation by asking the "right" questions and then listening precisely in a manner that is unselfconscious, non-judgmental, and open fully to the other's perspective. The "right" first question is based on knowledge of the context of the encounter and focused observation of the patient. Precise listening requires attention to denotation, connotation, inconsistency, tone of voice and sentence structure, as well as to the diverse behavioral signs the patient is presenting, undistracted by preconceptions. Based on what one hears and sees, one formulates the subsequent "right" questions. It is an engaged process, in which the physician expresses emotion and shares insight when it is likely to further the patient's care. Decisions emerge from ongoing interpersonal engagement. It entails commitment. If committed, engaged questioning and precise listening cease, then caring has ceased as well.

The path from a caring attitude with its accompanying close observation and en-

agement to caring in action is well illustrated by the following anecdote. The supervising perinatologist at a public clinic described an incident occurring at the beginning of a busy afternoon:

“My first patient was brought in, a Hispanic woman who spoke no English. A 5-year-old boy came into the exam room with her, I presumed her son. He looked hungry. A drug rep had visited us for lunch and left some candy; I went out and got some and gave it to the boy. I didn’t think it would do anything for his hunger, but I wanted to show him that I cared about him. He ate a piece and turned to his mother and, in Spanish, said, ‘This tastes better than the rat we had for supper last night.’”

Through a translator, the perinatologist determined the family was living in an abandoned building, surviving on scavenged food and rats that they were able to catch. While the translator assisted in obtaining needed social services, the perinatologist met with the residents who contributed money and a volunteer went out and bought food for the family before the patient left the clinic. He also arranged to assure a continuing supply of food until the social services support could be implemented.

Based on his incidental observation of the boy, who although was not the patient was a part of the patient’s context, the physician acted to communicate his caring, engaging with the boy through a piece of candy. The boy’s response to his action in turn prompted questions of the patient, entirely unrelated to the reason for her presence in the clinic — the “right” questions, it can be argued, which resulted in a comprehensive caring response. In the sense that the term is currently used in the clinical literature, one would be hard pressed to identify empathy in this encounter.

In fact, the perinatologist, a man of imposing stature, had been described by his patients as rarely touching them except to examine them and, equally, rarely making eye contact with them, usually just looking at his notepad as he recorded their answers

to his questions. Yet despite the absence of any of the behaviors customarily associated with empathy, his patients had been fiercely loyal to him, consistently commenting, “He always seems to know the right questions to ask to find out what was worrying me.”

This physician’s actions toward that boy were a demonstration of caring, a response to another based on a precise initial perception of the non-verbal expressions of the other (the “hungry” look), followed by an action in response to that perception (giving him candy), followed further by the questions raised by that initial interaction; the process more commonly will entail a series of questions, each in reaction to the response to the previous question, before a definitive action is undertaken. At the root of such attentiveness and focus on the patient are the caring feelings the physician has about the patient. Such feelings have a personal dimension in that they are not scripted exclusively by professional norms. Caring inevitably leads to engagement on a human level, transcending the professional relationship, seen most clearly in a physician reaching out to the family member of a patient such as their child.

Halpern provides an example of an empathic response with which a caring response can be contrasted. Halpern had been asked to consult with Ms. G, a 56-year-old artist with diabetes mellitus, renal failure, and bilateral above-the-knee amputations, who declined life-sustaining hemodialysis when her husband left her for another woman. As Halpern approached Ms. G’s room, she was met by a group of Ms. G’s women friends who told Halpern, “Ask her about her husband, that creep.” [11] Halpern asked Ms. G, “Is there anything besides your body that is hurting you?” The patient replied, “My husband doesn’t love me anymore. He told me that he’s in love with someone else. He moved in with her while I was in the hospital. He said that with my amputations and other medical problems, he could never be attracted to me.” Halpern relates how the patient’s grief then abruptly turned to rage against the doctor for bringing such feelings to the surface: “Why the hell

did you ask me to talk about this...Don't ask me any more questions! Get out of here!" [11] Halpern accepted the patient's rejection, and the patient subsequently died of renal failure while Halpern and all of the woman's physicians, after determining she was competent to refuse dialysis, helplessly stood by.

Reflecting on her failed experience with Ms. G, Halpern identifies "a more empathic" approach addressing Ms. G's "conflict between talking and not talking, thinking and not thinking" that she suggests would have been more fruitful than directly asking Ms. G about her feelings. We would have asked Ms. G about her feelings, as did Halpern, but we would have responded quite differently. Like her friends — or indeed, anyone who respects commitments — we were outraged by her husband's callous behavior and would have encouraged her to be as well. In response to her statement that she chose to die because he left her, in a tone mixing disbelief, disgust, and anger, we might have responded: "'I'll leave, if you insist. But before I do, there's something I need to say, and even though it may sound harsh to you, if I understand you correctly, it's something you need to hear. I hear you saying that you want to die so that asshole who once professed to you his undying love and commitment can walk off with everything you own and give it to that woman he's just moved in with! No! What you need is to get the nastiest divorce lawyer in town who'll take him for all he's worth for abandoning this poor, disabled woman — and I'll help you find that person! Don't reward the sonofabitch! Make him pay! And see how long his new girlfriend wants him around!"

The response we propose is just one approach that happens to reflect a heartfelt reaction to the patient's situation. Our objective in expressing our feelings is to convert the patient's grief into anger, to mobilize and energize her to defend her dignity rather than surrender to an unfortunate situation. What distinguishes this as a professional response, despite its crudeness, as compared to the response she might get from her women friends, is that our anger is directed at her passively allowing herself to

be victimized, rather than at her husband, who is unknown to us. Our decision to use offensively crude, vulgar language (arguably a boundary violation) to convey our anger and exhort a course of action is a caring response, based on a calculated assessment of the situation: that bold actions are needed, since the patient's emotional situation is extremely dire and will soon lead to her death; that she is clearly capable of rage; and that she is not lacking for support for the cause, given the number of angry women outside her door. That willingness to step outside professional norms when it might save a life is a hallmark of caring.

Focusing on the patient's ambivalence about talking about her feelings, as Halpern suggests would be the empathic response, validates the patient's assessment of the hopelessness of her situation and enables her to continue seeing refusal of dialysis as a reasonable option even as she talks about it — and her metabolic state deteriorates [11]. In contrast, neither our reaction nor our response to Ms. G is empathic; we neither feel what she is experiencing nor do we respond to its complexity. In fact, we directly challenge her with *our* perspective — a perspective that comes naturally to those who care about her, as it did to the friends waiting outside her door. Rather than treating emotion as an abstraction, we respond on an immediate, human, person-to-person level. Our response reframes her situation, transforming her from victim to potential victor.

### **CARING AS NURTURANCE, NOT LABOR**

Larson and Yao recently proposed that physicians consider empathy "emotional labor" that involves two types of acting: surface, in which the provider "forges empathic behavior," and deep, in which they "generate empathy-consistent emotional and cognitive reactions." [12] They state that the latter is consistent with Halpern's idea of "emotional reasoning" and both have been adopted successfully "by service workers, such as flight attendants and bill collectors" but are not yet widely appreciated in medicine. They ob-

serve that “regardless of how physicians use these two acting methods, the emotional labor of empathy requires effort, dedication, and patience,” and “the cognitive and emotional effort involved in empathy strain the already overextended psychological resource physicians have, contributing to burnout and even causing emotional pain for some.” They conclude that, despite the challenges, “we hope to establish the idea that empathy is a symbol of the health care profession.”

In this paper, we hope to turn the tide away from such a view. First, we question whether faking certain types of behavior (i.e., surface acting) is a form of empathy, since empathy is a feeling. Second, we concur with Peabody’s observation in his classic talk, “The Care of the Patient” that “the significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized, for in an extraordinarily large number of cases both diagnosis and treatment are directly dependent on it, and the failure of the young physician to establish this relationship accounts for much of his ineffectiveness in the care of patients.” [30] We regard that “intimate personal relationship between physician and patient” as qualitatively different from that between passengers and flight attendants, debtors and bill collectors, or customers and other service workers. Third, we question the transferability of the concept of “expressing organizationally desired emotions during service transactions” to such a relationship. And, most importantly, we question the value and relevance of such emotional effort to patient care.

In contrast to such “labor,” caring is intrinsically nurturing. It is enriching, rather than depleting. It is a response to who the patient is, rather than an act about who the physician should be. It is grounded in a deep desire to nurture others, as identified by Titmus in a study of blood donation and blood banking patterns worldwide. The findings of that study led Titmus to speak of altruism as the “biological need to help.” [31] Whether this need is genetically ingrained in the organism or learned, among social animals it runs deep. Examples of helping those in

need have been described among dolphins [32], among elephants [33], and among primates in the wild [34]. The physiologist Wright quotes a Talmudic aphorism by a renowned teacher, explaining his commitment to teaching: “More than the calf wishes to suck, does the cow yearn to suckle.” [35]

A central question is why, given the universality of the desire to care and nurture, so many physicians find caring difficult. We suspect it is because caring leads to engagement, and engagement is frightening. Engagement means intimacy, and intimacy involves risk on a human level, risk of rejection, risk of commitment, and acceptance of loss of control. We may chance such vulnerability in our personal relationships because we receive positive reinforcement and emotional support in return. Caring for patients brings a different kind of reward — the satisfaction of nurturing another individual during difficult times.

What are the implications of redefining the ideal approach to healing as caring rather than empathic? First, it challenges physicians to confront their fears rather than circumvent them, promoting personal and professional growth. Second, it taps into qualities that promote listening and learning rather than speculation and assumption. And third, a natural and concrete process replaces one that is laborious and abstract, bringing vitality back to a relationship that is increasingly formulaic. We have all heard it said about the occasional physician: “He cares for his patients as if they were family.” Such openness reflects the best characteristics of a healing profession and is a direct expression of the recognition, so well articulated by Peabody in his often quoted observation, “[T]he secret of the care of the patient is in caring for the patient.” [30]

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